MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, Washington 98687-2650	MDR Tracking No.: M4-04-4057-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Mutual Fire Insurance Company Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.: 973331551

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
06/15/03	07/14/03	E1399	$100.00	$0.00
05/15/03	06/14/03	E1399	$100.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "We have provided product information and pricing documentation along with the prescription from the patient's doctor of record. We are also including copies of EOBs from carriers who are paying at our price list."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "Attached is also documentation to show that this is the rate that Liberty mutual normally and consistently reimburses for stimulator rental. We do not feel that any additional reimbursement is warranted. Carrier's EOBs denied services as, "The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

HCPCS code E1399 item should be billed at the usual and customary rate of the DME provider. Carrier shall reimburse at a fair and reasonable rate per the MFG DME IX (C).

Per Commission Rule 133.307(j)(f), the reimbursement for these items would be at a "fair and reasonable" rate.

The requestor submitted product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicates that their charges were fair and reasonable per rule 133.307(g)(3)(D).

However, the carrier has the more compelling evidence of a fair and reasonable rate of reimbursement based on Ingenix and redacted EOBs indicating what they had paid to other providers.

Therefore, based on this information additional reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to additional reimbursement.

Ordered by:

Authorized Signature	Michael Bucklin	12/27/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____